MSS Post Pregnancy Screening Guide

rev 12.1.2009

Date: _____ Time visit started: _____ ☐AM ☐PM Time visit ended: _____ ☐AM ☐PM Home visit/ Office visit

Client name: _____ Client's date of birth: _____/_____/_____

Total pregnancy weight gain: _____ Current weight: _____

Estimated due date: _____/_____/_____ Delivery date: _____/_____/_____

Infant's Name: _____ Prenatal medical provider: _____

Plans for school? ☐ Y or ☐ N If yes, when? _____ Plans to work? ☐ Y or ☐ N If yes, when? _____

Living/housing situation: _____ Transportation to medical care:_____

Client (Women's) Questions		Risk and Purpose
Clarification Notes: Depending on the client's situation or background, questions need to be adapted. Here are examples of specific situations to keep in mind. • This pregnancy resulted in fetal loss or miscarriage- decide which questions need to be adjusted or skipped before talking with a client. Spend time supporting the woman and her plans related to future pregnancies. • Client seen by MSS in the post-pregnancy period only- You need to adjust questions and ask about prior pregnancy/parenting history.		**Bold=** MSS Risk factor
I am going to ask some questions to better understand how I might support you. Please let me know if you have any concerns or questions as we go along.		Rapport building
1.	How are you feeling? • Physically and Emotionally • In the last month, have you experienced loss of appetite, poor sleep not related to infant care, felt down, depressed or hopeless? ☐ Y or ☐ N (If yes) client needs standardized depression screening completed. If possible screen all women for depression	Rapport building, Baby blues **Mental Health**
2.	How did your delivery go? • Any issues related to delivery? (Infection, pain, incision, etc.)	Post partum Warning Signs i.e. fever, increased bleeding, **Delivered multiples**
3.	When did the doctor want to see you for follow up after your delivery? Did you go? ☐ Y or ☐ N When is the next appointment?	Importance of postpartum follow up care
4.	Did you experience any health concerns or medical conditions with this pregnancy? (review chart and clarify with client if anything else to add) • If medical issues known to provider then ask, "How is your _____ been since delivery?" • If new concern, "tell me more about _____?"	**Gestational Diabetes** **Gestational Hypertension** **Postpartum Hypertension**
5.	Do you have any medical concerns or diagnosis not related to your pregnancy (hypertension, diabetes, asthma, TB, mental health symptoms, etc)? ☐ Y or ☐ N If yes, how is your _____ been since your delivery?	**Diabetes, hypertension, Severe Mental Illness, depression**
6.	Are you currently taking any prescribed medications, over the counter medications, supplements, vitamins, and/or home remedies? ☐ Y or ☐ N (If no) go to Q #7 (If yes) What are they and how much/often do you take them? _____ _____ Have you discussed taking these meds/supplements with your medical provider? ☐ Y or ☐ N	**Medications related to psychiatric issues, diabetes, and hypertension.** **Non-prescriptive use of prescription drugs** Drugs/ breast feeding

7.	Have you discussed birth control methods with your doctor and/or partner? ☐ Y or ☐ N • Do you have a family planning method selected? ☐ Y or ☐ N If so, which method do you plan to use? _____ • What do you know about the importance of birth spacing? • What do you know about family planning resources available to you?	Family planning/birth spacing health message Family planning method FP and breastfeeding Referral family planning
8.	Who can you count on for help/support? • Do you get all the help you need with the baby? • Who can you talk to about stressful things in your life? • How is the FOB feeling about the new baby? • What advice are you getting from family and/or friends?	Social Support Probing questions that may provide more information about the clients needs and situation
9.	Have you ever received mental health services, counseling and/or treatment? ☐ Y or ☐ N If yes, client needs clinical assessment. In the last year, has your partner or FOB physically threatened or tried to hurt you? ☐ Y or ☐ N If so, tell me more _____	**Mental Health** **Intimate partner violence within last year**
10.	Have you ever smoked or used tobacco? ☐ Y or ☐ N (If no) skip to Q # 11 • (If yes) Did you use during the three months before you became pregnant? ☐ Y or ☐ N • Are you currently using tobacco? ☐ Y or ☐ N (If no) skip to Q # 11 (If yes)Are you trying to quit? ☐ Y or ☐ N (If yes) tell me more._____ (If no) Are you concerned about relapse? Y or N _____	**Current Maternal Tobacco Use**
11.	Does anyone who takes care of the baby smoke? ☐ Y or ☐ N Does anyone smoke inside your home or car with the baby present? ☐ Y or ☐ N	**Second hand smoke**
12.	When was the last time you drank alcohol? • Are you currently drinking alcohol? ☐ Y or ☐ N (If no), skip to Q # 13 (If yes)How much and how often? _____	**Alcohol Abuse- See definitions**
13.	When was the last time you used drugs? (If used drugs) are you currently using drugs? ☐ Y or ☐ N (If no, skip to Q # 14) • (If Yes)Are you interested in getting help to stop? ☐ Y or ☐ N • (If No) Are you concerned at all about relapse? ☐ Y or ☐ N	**Substance Use/Abuse- See definitions**
14.	Do you ever run out of food before the end of the month or cut down on the amount you eat to feed others? Y or N (If yes) Tell me more_____ Depending on feedback follow up with: • Are you currently on WIC? ☐ Y or ☐ N • Basic Food Program (food stamps)? ☐ Y or ☐ N • Are you aware of other food programs in the area? ☐ Y or ☐ N	**Food Insecurity** Referral- WIC, basic food program (food stamps), food banks, cooking /budgeting class at WIC.
15.	Is there any information or resources you would like us to help you with? ☐ Y or ☐ N If yes, what?	Referrals- housing, transportation, baby supplies

If a client is seen by MSS in the post pregnancy period only (not seen by MSS during this pregnancy) then the provider will need to cover the following information/questions:

1. Maternal Race
2. Pre-pregnancy BMI and total pregnancy weight gain
3. When did the clients prenatal care start
4. Is this the clients 1st pregnancy Y or N
5. If this is not the clients 1st pregnancy ask about pregnancy and parenting history
   - How many times has the client been pregnant? _____
   - Have any of the pregnancies been miscarriages, stillbirths or early infant deaths? Y or N.
   - (If yes) How many and when? _____
   - When did your last pregnancy end? _____

Staff Signature: _____ Date: _____

Client (mothers) name: _____ DOB: ____/_____/_____
Infant name: _____ DOB: ____/_____/_____

	MSS INFANT QUESTIONS	PURPOSE **BOLD** = MSS RISK FACTOR
16.	How is your baby doing?	Rapport building
17.	How much did your baby weigh at birth? _____ How long was he/she? _____ Current weight: _____	**LBW infant (<5 lbs 8 oz)** **Slow Weight gain**
18.	Did your baby have any of the following tests: • Newborn screening heel stick? ☐ Y or ☐ N If yes, when? _____ Results_____ • Jaundice? ☐ Y or ☐ N • Hearing test? ☐ Y or ☐ N (If yes) Do you know your baby's hearing results? ☐ Y or ☐ N _____ Were any more hearing tests recommended? ☐ Y or ☐ N If needed, when will you follow up with more hearing testing?	*All infants should have 2 newborn screening heel sticks- the first shortly after birth and then again around 1-2 weeks of age. Refer back to medical care provider as needed. Health message on wellness checks and infant screening. **Infant with health issue –** Hearing loss, genetic disease, etc.
19.	Does your baby have an appointment with their doctor? ☐ Y or ☐ N (If yes) When? _____ Continue to Q#5 (If no) When do you plan on taking your baby in to see the doctor?	Importance of wellness checks Medical care
20.	Has the doctor identified any concerns or medical conditions for your baby? ☐ Y or ☐ N (If yes) Tell me more. Is your baby taking any medications? ☐ Y or ☐ N (If yes) Tell me more.	**Infant health issue**
21.	Do you know what signs to look for that might mean your baby is sick or needs to be seen by a doctor? ☐ Y or ☐ N	Health message
22.	How is **breastfeeding** going? • How often does the baby feed in 24 hours? _____ • How long does your baby nurse? _____ • Are you having any problems breastfeeding? ☐Y or ☐N (If yes) Tell me more. If **formula feeding**, "How do you mix the formula"? • How much does your baby drink? _____ • How do you know when your baby is hungry? Full? • Do you always hold your baby when feeding? ☐ Y or ☐ N (If no), tell me more	Development & Feeding Relationship Exclusive breastfeeding or not **Breastfeeding Complications- inadequate milk transfer/ineffective suck** Incorrect mixing of formula Very Restrictive Feeding Propping of bottle
23.	What else do you give your baby to drink? How much? Do you ever put cereal in the bottle? Y or N	Evaluate for/health message- cow's milk, goat's milk, sports drinks, sweetened drinks, water
24.	How many wet diapers does your baby have in 24 hrs? How many dirty diapers (bowel movements) does your baby have in 24 hours? What do the dirty diapers (bowel movements) look like?	**Breastfeeding Complications**- Inadequate stooling
25.	Do you have any questions or concerns about your baby's: Feeding? Growth? Health? Care? Other?	Parents needs
26.	Have you applied for the baby's birth certificate? Social Security #? Do you have the baby's immunization card? Have you notified DSHS about the change of circumstances in your pregnancy? Are you considering traveling out of the country?	Important Documents